Template for Service and Facility Specific Policies

I. ESSHB 1688 Guidance

a) The need for a new and regularly updated set of service and facility specific policies that guide certificate of need decisions [Section 3.2.a]

II. Policy Questions *(with potential answers to initiate discussion)*

A. ***Who should be the CON decision-makers?***
- applications should be analyzed by CON staff, recommended by CON Chief, decision by Secretary of Department of Health,
- advisors will include other state agencies, and
- no ex parte contact.

B. ***How should the process of decision-making be conducted?***
CON review should be based on:
- a state health plan, and
- detailed criteria and standards which are updated at least bi-annually after consultation with a Technical Advisory Committee.

C. ***What factors should be considered in making the decision?***
In addition to the existing criteria of community need, financial feasibility, structure and process of care, and cost containment, additional factors should include:
- information from public hearings, including business
- availability of reimbursement funds,
- less costly alternatives,
- financial accessibility to all residents,
- availability of alternative services,
- charity care in excess of 5%,
- consideration for special populations, and
- impact on selected quality indicators.

D. ***When are decision-making timeframes and considerations?***
- applications will be grouped into periodic review cycles with scheduled decision dates,
- review cycles will not exceed 120 days,
- competing applications will be batched into the same decision cycle,
- separate decision cycles will be established for full vs. expedited reviews, and
- all projects will have quarterly performance monitoring for at least 5 years.

E. ***Where are the venues and methods for decision-making?***
- all applications will be eligible for electronic submission,
- posted in a public website, and
- decisions announced in a public venue subsequent to public input.

F. ***Why are decisions made, including rationale and impact?***
- objective, out-come based, data-supported,
- publicly responsive and
- in keeping with the state health plan.

Additional Resource Information

I. Criteria for Current CON Program (RCW 70.38.115)

(2) Criteria for the review of certificate of need applications, except as provided in subsection (3) of this section for health maintenance organizations, shall include but not be limited to consideration of the following:

(a) The need that the population served or to be served by such services has for such services;

(b) The availability of less costly or more effective alternative methods of providing such services;

(c) The financial feasibility and the probable impact of the proposal on the cost of and charges for providing health services in the community to be served;

(d) In the case of health services to be provided,

(i) the availability of alternative uses of project resources for the provision of other health services,

(ii) the extent to which such proposed services will be accessible to all residents of the area to be served, and

(iii) the need for and the availability in the community of services and facilities for osteopathic physicians and surgeons and allopathic physicians and their patients. The department shall consider the application in terms of its impact on existing and proposed institutional training programs for doctors of osteopathic medicine and surgery and medicine at the student, internship, and residency training levels;

(e) In the case of a construction project, the costs and methods of the proposed construction, including the cost and methods of energy provision, and the probable impact of the construction project reviewed:

(i) on the cost of providing health services by the person proposing such construction project, and

(ii) on the cost and charges to the public of providing health services by other persons;

(f) The special needs and circumstances of osteopathic hospitals, nonallopathic services and children's hospitals;

(g) Improvements or innovations in the financing and delivery of health services which foster cost containment and serve to promote quality assurance and cost-effectiveness;

(h) In the case of health services proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those proposed;

(i) In the case of existing services or facilities, the quality of care provided by such services or facilities in the past;

(j) In the case of hospital certificate of need applications, whether the hospital meets or exceeds the regional average level of charity care, as determined by the secretary; and

(k) In the case of nursing home applications:

(i) The availability of other nursing home beds in the planning area to be served; and

(ii) The availability of other services in the community to be served. Data used to determine the availability of other services will include but not be limited to data provided by the department of social and health services.

(3) A certificate of need application of a health maintenance organization or a health care facility which is controlled, directly or indirectly, by a health maintenance organization, shall be approved by the department if the department finds:

(a) Approval of such application is required to meet the needs of the members of the health maintenance organization and of the new members which such organization can reasonably be expected to enroll; and

(b) The health maintenance organization is unable to provide, through services or facilities which can reasonably be expected to be available to the organization, its health services in a reasonable and cost-effective manner which is consistent with the basic method of operation of the organization and which makes such services available on a long-term basis through physicians and other health professionals associated with it.

A health care facility, or any part thereof, with respect to which a certificate of need was issued under this subsection may not be sold or leased and a controlling interest in such facility or in a lease of such facility may not be acquired unless the department issues a certificate of need approving the sale, acquisition, or lease.

II. State Examples of Policies, Criteria and Principles

A. Michigan General Criteria

1. Applicability
Requirements for the approval of the initiation, expansion, replacement, relocation, or acquisition of services and facilities for all projects to be reviewed under CON.

2. Definitions
Meaning of words, phrases, titles and processes used in operating the program.

3. Community need
Service and facility specific performance expectations and population-based use rates.

4. Project delivery conditions
An applicant must agree to compliance with the CON standards, applicable safety and operating standards, and other provisions as defined in their proposal.

5. Resource data
"Service Utilization List" of all health care facilities and services is annually published that includes at least actual adjusted procedures, number of units, and their locations.

6. Health Service Areas
Counties or areas assigned to each of the health service areas including rural counties, micropolitan statistical area counties, and metropolitan statistical area counties.

7. Financial Feasibility
The cost of acquisition, renovation and/or construction, loan rates, cash flow estimates and future charge rates must be reported.

8. Other considerations
Other factors which may impact the acceptability of a proposal such as research, Medicaid participation, and other provisions.

9. Project Monitoring
At least annual (quarterly preferred) performance reporting of service utilization, charges and conditions after a certificate of need has been issued.

10. Update Frequency
The detailed criteria and standards should be systematically updated every two years.

B. North Carolina Basic Principles

Basic Principles Governing the Development of this Plan

1. Promote Cost-Effective Approaches: In these times of high and increasing costs of most health care services, North Carolina is committed to promoting cost-effective approaches to the provision and purchase of health services. The Department of Health and Human Services encourages the development and use of cost-effective alternative approaches to health care delivery by providers of care, consumers and third-party payers. The Department encourages the development of health care delivery networks, accountable health plans, accountable health carriers, community care networks, integrated delivery systems or any system which provides for most cost-effective delivery of health care services through collaborative efforts among health care providers. Other examples of cost-effective approaches include the development of prepaid health plans, appropriate uses of out-patient treatment modalities, community-based services, innovative reimbursement programs, and conversion of underutilized existing facilities to uses for which there is a demonstrated need.

2. Expand Health Care Services to the Medically Underserved: The Department of Health and Human Services recognizes the need to ensure access to health care in as equitable a manner as possible. Individuals who are medically underserved include low-income persons, racial and ethnic minorities, and disabled persons.

   It is important to recognize that a variety of public funds are used to address the needs of the medically underserved, including Medicare, Medicaid, State and local funding of public health clinics and community mental health centers, local funding of community hospitals, and some State programs that help individuals with specialized health problems (i.e., Children's Special Health Services Program, Sickle Cell Anemia Program, Sudden Infant Death Syndrome Program, etc.). In addition, many providers serve low-income persons by increasing the charges paid by insured patients, although the extent of this cost-shifting is not always known. As the health care system becomes more competitive, providers may be forced to decrease their cost-shifting practices, resulting in an increased reliance on public funds or a decrease in services available to the medically underserved.

3. Encourage Quality Health Care Services: The Department of Health and Human Services is committed to assuring citizens of North Carolina adequate access and availability to quality health care at a reasonable cost.

   The Department of Health and Human Services recognizes the practical limits of this commitment, i.e., the Department of Health and Human Services does not have resources adequate to guarantee each citizen access to every health service that could possibly benefit that person throughout her/his lifetime. Therefore, the Department, in allocating its available resources, gives priority to health services which are considered to be:
   a) cost-effective, and
   b) potentially beneficial to the majority of North Carolina's citizens.

   Further, the Department of Health and Human Services will attempt to influence resource allocation decisions by other public and private entities in the same direction. Trade-offs among cost containment, access and quality complicate decisions about acceptable or desirable levels of care as well as the trend toward using complex technology, treating a

greater mix of cases, and dealing with more chronic conditions. In spite of these complexities, it is important that quality of care be assured.

The State Health Planning Process

Throughout the development of the State Medical Facilities Plan, there are opportunities for public review and comment. Sections of the Plan, including the policies and methods for projecting need, are developed with the assistance of committees of the North Carolina State Health Coordinating Council. The committees submit their recommendations to the Council for approval. A Proposed Plan is assembled and made available to the public. Public hearings on the Plan are held throughout the State in early summer. Comments and petitions received during this period are considered by the Council and, upon incorporation of all changes approved by the Council, a final draft of the Plan is presented to the Governor for his review and approval. With the Governor's approval, the State Medical Facilities Plan becomes the official document for health facility and health service planning in North Carolina for the specified calendar year.

Other Publications

Information concerning publications or the availability of other data related to the health planning process may be obtained by writing or calling the Medical Facilities Planning Section, Division of Facility Services, 2714 Mail Service Center, Raleigh, North Carolina 27699-2714, Telephone Number: (9 19) 855-3865, FAX Number (919) 715-4413.

Note

Determinations of need for services and facilities in this Plan do not imply an intent on the part of the Division of Medical Assistance of the N.C. Department of Health and Human Services to participate in the reimbursement of the cost of care of patients using services and facilities developed in response to this need.

C. Kentucky General Critieria for Acute Care

An application to establish a new acute care hospital shall be consistent with this Plan if the following criteria are met:

1. The applicant shall demonstrate that sufficient need for the proposed facility exists and that the establishment of the proposed facility would not result in the unnecessary duplication of services by documenting one or more of the following:
   a. The overall occupancy of existing acute care beds in existing licensed acute care hospitals located in the planning area exceeds eighty (80) percent according to the most recent edition of the *Kentucky Annual Hospital Utilization and Services Report*;
   b. The adjusted revenue of each licensed acute care hospital located within the planning area exceeded one-hundred and fifty (150%) of the state mean adjusted revenue, for acute care hospitals, during each of the previous three (3) fiscal years; or
   c. All licensed acute care hospitals located within the planning area have experienced one or more of the following:
      i. Final termination of their Medicare or Medicaid provider agreement;
      ii. Final revocation of the their hospital license issued by the Cabinet for Health and Family Services' Office of Inspector General; or
      iii. Final revocation of their hospital accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

2. The applicant shall demonstrate the ability to provide safe, efficient and quality care and treatment to all individuals seeking medical and/or surgical services by documenting the following:
   a. The individual(s) responsible for the operation, management and day-to-day control of the proposed facility has a documented history of providing healthcare services in conformity with federal and state standards. Moreover, no such individual has had any license or certification denied, revoked or involuntarily terminated, or has been excluded from participation in Medicare or Medicaid, or been convicted of fraud or abuse of these programs;
   b. Written policies and/or protocols that implement measures to assure quality control with respect to the life, health and safety of individuals seeking care and treatment at the proposed facility. These include documented plans of action that not only serve to prevent, but also identify, diagnose, control and treat injuries or problems including, but not limited to, the following:
      i. Acute myocardial infarctions sustained after arrival at the proposed facility;
      ii. Hospital-acquired infections;
      iii. Medication errors;
      iv. Hospital-acquired pneumonia;
      v. Death in low mortality Diagnosis Related Groups;
      vi. Re-admittance within twenty-four (24) hours of discharge;
      vii. Foreign objects not removed during surgical procedures;
      viii. Post-operative respiratory failure;
      ix. Post-operative sepsis;
      x. Decubitus ulcers;
      xi. Adverse reactions to the administration of medications and/or transfusions; and
      xii. Injuries sustained as a result of falls on the proposed facility's premises.

c. Written policies and/or protocols that implement measures to assure the proper use and utilization of all equipment to be maintained on the proposed facility's property which would be used in the care and treatment of potential patients;
d. The applicant must identify the licensed physicians that would provide care and treatment to patients at the proposed facility The applicant must further demonstrate that the retention of such individuals would not adversely affect the clinical care and treatment offered at other licensed acute care hospitals located within the planning area; and
e. The applicant must demonstrate that it has identified and would retain trained, experienced or licensed personnel to provide efficient and effective clinical care and treatment to the proposed facility's patients. The applicant must further demonstrate that the retention of such individuals would not adversely affect the clinical care and treatment offered at other licensed acute care hospitals located within the planning area.

3. The applicant shall demonstrate the ability to provide cost-effective services by documenting the following:
   a. The proposed facility's payor mix would be comparable to all other licensed acute care hospitals located within the planning area; and
   b. A written business plan through which the economic performance and financial strength of the proposed facility would be comparable to the existing acute care hospitals located within the planning area. Specifically, the applicant must document that its adjusted revenue would not exceed one-hundred and fifty (150%) of the state mean adjusted revenue.

4. The applicant shall demonstrate that the proposed facility would increase access to twenty-four (24) hour acute care and treatment by documenting the following:
   a. The proposed facility would provide care on an immediate and emergent basis through an established Emergency Department; and
   b. The proposed facility would provide emergency services to all individuals that seek care and treatment there, regardless of the individual's ability to pay for such services.

5. The applicant shall demonstrate both its intention as well as its ability to provide the same or substantially similar clinical services offered by the existing acute care hospitals located within the planning area.

6. The maximum number of acute care beds that may be approved for the purpose of constructing or establishing a new acute care hospital shall be based on volume projected five (5) years from the filing of the application. Approval will be based on the higher of:
   a. The applicant's credible forecast of future utilization; or
   b. A regression analysis projection of patient day trends over a five (5) year timeframe.

7. The applicant shall obtain certificate of need approval for each service it proposes to offer by satisfying the review criteria for each service set forth within this Plan.

8. No application for a specialty hospital shall be consistent with this Plan.